Personal Care. Professional Results.

☐ **TYLER OFFICE**
2501 E. Fifth St.
Tyler, TX 75701
(903) 593-7977
(903) 593-7988 fax

☐ **PALESTINE OFFICE**
112 Medical Dr.
Palestine, TX 75801
(866) 318-0803

Email: support@hearingahs.com

Our goal is to provide you with excellent patient care and treat you just like family!

1 PATIENT INFORMATION

Name:	DOB:	SSN:
Address:		
City	State	Zip
Phone:	Cell Phone:	
Email:		
Marital Status: ☐ Single ☐ Widow ☐ Married		
Name of Spouse:		
Employer:		Retired: ☐ YES ☐ NO
Insurance: ☐ Medicare ☐ Medicaid ☐ Other:		
How did you hear about us?: ☐ Newspaper ☐ Mail ☐ TV ☐ Doctor ☐ Yellow Pages ☐ Other:		

2 ABOUT EAR

Deformity of the ear?	☐ YES ☐ NO
Do you have any pain in your ears?	☐ YES ☐ NO
Sudden or Rapid hearing loss in the past 90 days?	☐ YES ☐ NO
Sudden or Long term dizziness?	☐ YES ☐ NO
Hearing Loss in one ear in the last 90 days?	☐ YES ☐ NO
Have you ever seen a doctor for wax removal?	☐ YES ☐ NO
Drainage from either ear in the past 90 days?	☐ YES ☐ NO
Which ear is worse?	☐ LEFT ☐ RIGHT ☐ SAME

3 ABOUT YOUR HEARING

Do you currently wear Hearing Instruments?	☐ YES ☐ NO If yes, how long?
When was your last hearing test?	By Whom?
What were the findings / recommendations?	
Does anyone in your family have a hearing problem?	☐ YES ☐ NO Relationship?
How long have you been experiencing hearing difficulties? ☐ Current ☐ 1 Year ☐ 1–2 Years ☐ 2–5 Years ☐ Over 5 Years	
Do you…	
Have difficulty hearing on the phone/cell phone?	☐ YES ☐ NO Which ear do you use? ☐ Right ☐ Left
Have difficulty understanding the television or radio?	☐ YES ☐ NO
Have difficulty when attending religious (or similar) functions?	☐ YES ☐ NO
Have difficulty when talking with your spouse or other family members?	☐ YES ☐ NO
Have trouble understanding voices when background noise is present?	☐ YES ☐ NO
Please describe any other hearing difficulties you are experiencing?	

4 MEDICAL HISTORY

Primary Care Physician:	Telephone:	
Have you seen a doctor specializing in diseases of the ear?	☐ YES ☐ NO Dr. Name	Date Seen
Have you ever had any type of ear surgery?	☐ YES ☐ NO	
Type of Surgery?	By Whom?	When?
Are you currently being treated for any disease?	☐ YES ☐ NO	
If yes, please describe?		
Are you currently taking any medications?	☐ YES ☐ NO	
If yes, please describe?		

AHS Audiology & Hearing Solutions may call you to follow up regarding the information you have provided here and to provide you with information on treatment or new products that may benefit you.

Signature: Date: